

COMMONWEALTH OF KENTUCKY  
Cabinet for Health and Family Services  
Office of the Inspector General  
Division of Regulated Child Care

Licensed-Request for Appeal or Informal Dispute Resolution

For Official Use Only  
DATE RECEIVED BY DRCC

NAME:	_____	_____
	(last name)	(first name)
CHILD CARE CENTER NAME:	_____	
MAILING ADDRESS:	_____	
	(street address or P O Box number)	
	_____	_____
	(city)	(state)
	_____	_____
		(zip code)
LICENSE NUMBER:	_____	
PHONE NUMBER:	_____	
CELL PHONE NUMBER:	_____	

REPRESENTED BY ATTORNEY:	<input type="checkbox"/> NO	<input type="checkbox"/> YES
ATTORNEY'S NAME:	_____	
ADDRESS:	_____	
	(Street address or P O Box number)	
	_____	_____
	(city)	(state)
	_____	_____
		(zip code)
PHONE NUMBER:	_____	

I AM REQUESTING AN INFORMAL DISPUTE RESOLUTION CONFERENCE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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I AM APPEALING THE FOLLOWING ACTIONS: (Check appropriate box/boxes)
<input type="checkbox"/> CIVIL MONEY PENALTY
<input type="checkbox"/> EMERGENCY SUSPENSION
<input type="checkbox"/> DENIAL OF LICENSURE
<input type="checkbox"/> REVOCATION OF LICENSE
<input type="checkbox"/> OTHER (Specify): _____

[illegible]

DATE YOU RECEIVED NOTICE OF ACTION YOU ARE APPEALING: \_\_\_\_\_  
(Attach a copy of any written notice which you received relating to this Appeal.)

\_\_\_\_\_  
SIGNATURE DATE

\_\_\_\_\_  
SIGNATURE DATE

ATTORNEY'S SIGNATURE (if any)	DATE
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ATTORNEY'S SIGNATURE (if any)	DATE
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THIS FORM IS TO BE MAILED OR DELIVERED TO:

CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE INSPECTOR GENERAL  
DIVISION OF REGULATED CHILD CARE, 5 E-F  
275 EAST MAIN STREET  
FRANKFORT, KENTUCKY 40621

ATTENTION: APPEAL

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